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Michigan Department of Labor & Economic Growth
Equal Opportunity Office
3024 W. Grand Boulevard, Suite 12-350
Detroit, Michigan 48202
FAX: (313) 456-2477

ERGONOMIC ASSESSMENT REQUEST BY EMPLOYEE

Please type or print a response to each of the items below in accordance with the attached instructions. Return the completed form and attachments to the Equal Opportunity (EO) Office. The information you submit will be treated as confidential to the extent permitted. Please note that your request cannot be processed unless you attach medical documentation (noting your diagnosis and recommending an ergonomic evaluation), as well as a medical release form. For further information, contact the EO Office at (313) 456-2461.

1. Name	2. Employee ID #	3. Bureau / Division

4. Work County	5. Classification	6. Date of Birth
		/ /

7. Work Address (home address if on leave)	8. Telephone Numbers
	Work ( ) -
	Home ( ) -

9. Describe your current job duties that are affected by your medical condition.

10. Describe the functional limitations caused by your medical condition for which you are requesting an ergonomic assessment. Use additional pages if necessary. (Attach medical documentation.)

11. Describe the modification needed and why you believe it would minimize or eliminate the functional limitations described in question 10.

12. Immediate Supervisor Name and Telephone Number

( ) -

13. Employee's Signature	Date
	/ /

CONFIDENTIALITY

Information in your request will be held confidential to the extent allowed by law.

Information obtained or generated in processing your request may be released to individuals or agencies participating in the evaluation of your request.

INSTRUCTIONS FOR COMPLETING THE ERGONOMIC ASSESSMENT REQUEST FORM

To be completed by the employee and returned to the Equal Opportunity Office (EO Office). Consult the EO Office for assistance, if necessary.

Questions	**Instructions**
Questions 1 – 8	Complete all personal information
Question 9	Describe which job duties you are (or anticipate) having difficulty performing because of your medical condition.
Question 10	Describe the functional limitations of your condition which interfere (or may interfere) with performing the duties of your job. Please attach medical documentation regarding your condition and functional limitations.
Question 11	Describe the modifications you are requesting and indicate why you believe it would help.
Question 12	Enter the name and telephone number of your immediate supervisor.
Question 13	Sign and date the form. If you are unable to sign the form, your designated representative may sign on your behalf. Also attached the DMB-OSE 2209 At-Risk-Medical Release form.

FILING BY EMPLOYEE

Make a copy of this form. Keep the copy and submit the original to the EO Office.

RESPONSE TIME

A response to the request or a request for an evaluation should be given to the employee from the EO Office within eight weeks after the date your completed Ergonomic Assessment request is received. If necessary, follow up with the EO Office.